FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016949

Facility Name: St Clara's Manor

Address: 200 Fifth Street (Number) Lincoln (City) 62656 (Zip Code)

County: Champaign

Telephone Number: (217)735-1504 **Fax #** ( )

HFS ID Number: 376075710001

Date of Initial License for Current Owners: 1972

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Frank Shepke
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Craig L. Ater, Senior V.P. & CFO
(Firm Name & Address) Heritage Enterprises
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	140	Skilled (SNF)	140	51,100	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,056	18,676	4,527	43,259	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	20,056	18,676	4,527	43,259	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.66%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 4,527

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number St Clara's Manor # 0016949 **Report Period Beginning:** 1/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	250,389	23,503		273,892		273,892		273,892			1
2	Food Purchase		220,450		220,450		220,450		220,450			2
3	Housekeeping	134,494	18,777		153,271		153,271		153,271			3
4	Laundry	61,115	12,280		73,395		73,395		73,395			4
5	Heat and Other Utilities			116,682	116,682		116,682		116,682			5
6	Maintenance	64,074	43,718	34,854	142,646		142,646		142,646			6
7	Other (specify):*											7
8	**TOTAL General Services**	510,072	318,728	151,536	980,336		980,336		980,336			8
	B. Health Care and Programs											
9	Medical Director			2,888	2,888		2,888		2,888			9
10	Nursing and Medical Records	1,596,223	139,166	7,773	1,743,162		1,743,162		1,743,162			10
10a	Therapy		140,985	269,517	410,502	(182,304)	228,198		228,198			10a
11	Activities	52,203	5,646		57,849		57,849		57,849			11
12	Social Services	32,065	243	3,996	36,304		36,304		36,304			12
13	CNA Training		500		500		500		500			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,680,491	286,540	284,174	2,251,205	(182,304)	2,068,901		2,068,901			16
	C. General Administration											
17	Administrative	91,924			91,924		91,924		91,924			17
18	Directors Fees											18
19	Professional Services			343,036	343,036		343,036	(5,019)	338,017			19
20	Dues, Fees, Subscriptions & Promotions			109,951	109,951	(76,650)	33,301	(21,796)	11,505			20
21	Clerical & General Office Expenses	80,893	11,148	17,675	109,716		109,716		109,716			21
22	Employee Benefits & Payroll Taxes			547,539	547,539		547,539		547,539			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			4,727	4,727		4,727	(2,728)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			85,907	85,907		85,907		85,907			26
27	Other (specify):*			60,000	60,000		60,000	(60,000)				27
28	**TOTAL General Administration**	172,817	11,148	1,170,834	1,354,799	(76,650)	1,278,149	(89,543)	1,188,606			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,363,380	616,416	1,606,544	4,586,340	(258,954)	4,327,386	(89,543)	4,237,843			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Clara's Manor #0016949 **Report Period Beginning:** 1/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			141,396	141,396		141,396		141,396			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,704	3,704		3,704	(3,704)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,434	7,434		7,434	(366)	7,068			35
36	Other (specify):*											36
37	**TOTAL Ownership**			152,534	152,534		152,534	(4,070)	148,464			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					182,304	182,304		182,304			39
40	Barber and Beauty Shops		231	16,852	17,083		17,083		17,083			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					76,650	76,650		76,650			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		231	16,852	17,083	258,954	276,037		276,037			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,363,380	616,647	1,775,930	4,755,957		4,755,957	(93,613)	4,662,344			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(366)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(3,704)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(375)	20		17
18	Fines and Penalties				18
19	Entertainment	(2,728)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,019)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	27		24
25	Fund Raising, Advertising and Promotional	(21,421)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule **Real Estate Taxes**		33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (93,613)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (93,613)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

St Clara's Manor

ID# 0016949

Report Period Beginning: 1/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		(366)	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(375)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(5,019)	19	22
23				23
24		(60,000)	27	24
25		(21,421)	20	25
26				26
27				27
28				28
29		0	33	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(87,181)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number St Clara's Manor **# 0016949** **Report Period Beginning: 1/01/05** **Ending: 12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,019)	0	0	0	0	0	0	0	0	0	0	(5,019)	19
20	Fees, Subscriptions & Promotions	(21,796)	0	0	0	0	0	0	0	0	0	0	(21,796)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,728)	0	0	0	0	0	0	0	0	0	0	(2,728)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(60,000)	0	0	0	0	0	0	0	0	0	0	(60,000)	27
28	**TOTAL General Administration**	(89,543)	0	0	0	0	0	0	0	0	0	0	(89,543)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(89,543)	0	0	0	0	0	0	0	0	0	0	(89,543)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number St Clara's Manor **#** 0016949 **Report Period Beginning:** 1/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,704)	0	0	0	0	0	0	0	0	0	0	(3,704)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(366)	0	0	0	0	0	0	0	0	0	0	(366)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,070)	0	0	0	0	0	0	0	0	0	0	(4,070)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(93,613)	0	0	0	0	0	0	0	0	0	0	(93,613)	45

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$		100.00%	$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [xx]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Interest Income											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number St Clara's Manor **#** 0016949 **Report Period Beginning:** 1/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	**8**
	2001	**9**
	2002	**10**
	2003	**11**
	2004	**12**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Clara's Manor COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0016949

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? xx YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 53,286 B. General Construction Type: Exterior Brick/Wood Frame Wood Number of Stories 1

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 38,660	1
2					2
3	TOTALS			$ 38,660	3

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140				$ 1,624,882	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1976			1976	65,361						9
10	1978			1978	3,451						10
11	1980			1980	8,793						11
12	1981			1981	11,439						12
13	1982			1982	3,826						13
14	1983			1983	1,535						14
15	1984			1984	4,031						15
16	1985			1985	7,859						16
17	1986			1986	2,541						17
18	1987			1987	10,753						18
19	1988			1988	1,006						19
20	1989			1989	1,431						20
21	1991			1991	8,799						21
22	1992			1992	17,963						22
23	1993			1993	15,564						23
24	1994			1994	51,022						24
25	1995			1995	124,932						25
26	1996			1996	102,380						26
27	1997			1997	39,247						27
28	Fire Sprinkler			1998	22,151						28
29	Transfer Switch			1998	4,819						29
30	Water Line			1998	6,379						30
31	Soffits			1998	3,950						31
32	Generator			1998	3,164						32
33	Heating, A/C Improvements			1998	8,664						33
34	C/O Allocation										34
35	Book Depreciation					87,001		87,001		1,809,709	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Windows	1998	$ 3,422	$		$	$	$	37
38	Sidewalks	1998	2,963						38
39	Fixtures	1999	224						39
40	Faucets	1999	1,532						40
41	Water System Improvements	1999	7,920						41
42	Windows	1999	23,400						42
43	Fixtures	1999	2,812						43
44	Faucets	1999	1,404						44
45	Heating & Cooling Unit	2000	4,050						45
46	Water System	2000	37,203						46
47	Glass Doors	2000	1,145						47
48	Remodeling	2000	4,581						48
49	Plumbing	2000	4,128						49
50	Windows	2000	600						50
51	Plumbing	2000	1,702						51
52	4 Ton Condensing Unit	2000	4,453						52
53	Windows	2000	5,400						53
54	Exhaust Fan	2000	1,100						54
55	Heating & Cooling Units	2000	4,050						55
56	Doors	2000	4,081						56
57	Porch Ceiling	2000	4,050						57
58	Exhaust Fan	2000	2,046						58
59	Concrete Pad	2000	5,398						59
60	Fire Sprinkler	2001	1,304						60
61	Faucets	2001	3,432						61
62	Patio Roof	2001	1,532						62
63	Exhaust Fan	2001	1,000						63
64	A/C Unit	2001	16,312						64
65	A/C Kitchen	2001	6,850						65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,314,036	$ 87,001		$ 87,001	$	$ 1,809,709	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,314,036	$ 87,001		$ 87,001	$	$ 1,809,709	1
2									2
3	Code Alert Alarm	2002	5,600						3
4	Ceiling Fan	2002	996						4
5	Heat Cool Units	2002	4,550						5
6	Carpet	2002	2,361						6
7	Seal Coat Parking Lot	2002	3,342						7
8	Walk-In Cooler	2002	17,518						8
9	Roof Replacement	2002	92,577						9
10	Door	2002	824						10
11	Wide Area Network Wiring	2002	3,167						11
12									12
13	Roof Replacement	2003	53,524						13
14	Facility Wiring	2003	11,041						14
15	Remodel Bathrooms	2003	33,616						15
16	Closet Doors	2003	4,188						16
17	Water Heaters and Storage Tank	2003	38,929						17
18									18
19	Furnace	2004	1,800						19
20	Remodel Activity room-- carpet	2004	2,624						20
21	Heat Cool Units	2004	8,094						21
22	Remodel Employee Lounge	2004	2,955						22
23	Electric Door opener	2004	1,598						23
24	Drain Grate	2004	2,350						24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,605,690	$ 87,001		$ 87,001	$	$ 1,809,709	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,605,690	$ 87,001		$ 87,001	$	$ 1,809,709	1
2									2
3	Code Alert System	2005	726						3
4	Kitchen Hood	2005	1,662						4
5	Wander System	2005	2,543						5
6	Hallway remode -- Paint and carpet	2005	20,919						6
7	A/C Units	2005	1,187						7
8	Fire Supression	2005	1,845						8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,634,572	$ 87,001		$ 87,001	$	$ 1,809,709	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,153,962	$ 54,395	$ 54,395	$		$ 921,976	71
72	Current Year Purchases	14,864						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,168,826	$ 54,395	$ 54,395	$		$ 921,976	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,842,058	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 141,396	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 141,396	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,731,685	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Independent Living Center	$ 591,233	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 591,233	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 7,068 Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		500		500
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 500	$	$ 500
10	SUM OF line 9, col. 1 and 2 (e)	$ 500			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 58,631	$		$ 58,631	1
2	Licensed Speech and Language Development Therapist		hrs			13,058			13,058	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			155,924	585		156,509	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				140,400		140,400	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					41,904			41,904	13
14	TOTAL			$		$ 269,517	$ 140,985		$ 410,502	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number St Clara's Manor **#** 0016949 **Report Period Beginning:** 1/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,404,232	$	1
2	Cash-Patient Deposits	12,673		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	553,124		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	105,281		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(56,823)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,018,487	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	65,863		13
14	Buildings, at Historical Cost	2,596,806		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,179,387		16
17	Accumulated Depreciation (book methods)	(2,731,685)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,110,371	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,128,858	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 267,996	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,673		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	142,353		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,807		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 448,829	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 448,829	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,680,029	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,128,858	$	48

***(See instructions.)**

Facility Name & ID Number St Clara's Manor # 0016949 **Report Period Beginning:** 1/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,889,493	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,889,493	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	790,536	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 790,536	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,680,029	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,428,825	1
2	Discounts and Allowances for all Levels	(788,541)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,640,284	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	564,491	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 564,491	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,101	12
13	Barber and Beauty Care	19,112	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	263,572	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	206	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 284,991	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	56,727	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 56,727	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,546,493	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	980,336	31
32	Health Care	2,251,205	32
33	General Administration	1,354,799	33
	B. Capital Expense		
34	Ownership	152,534	34
	C. Ancillary Expense		
35	Special Cost Centers	17,083	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Non Nursing Home Expenses		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,755,957	40
41	**Income before Income Taxes (line 30 minus line 40)****	790,536	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 790,536	43

*** This must agree with page 4, line 45, column 4.**

**** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,949	2,133	$ 69,318	$ 32.50	1
2	Assistant Director of Nursing	2,012	2,136	62,798	29.40	2
3	Registered Nurses	2,339	2,483	52,818	21.27	3
4	Licensed Practical Nurses	29,686	32,116	513,936	16.00	4
5	CNAs & Orderlies	83,871	89,912	852,211	9.48	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,053	2,254	45,142	20.03	8
9	Activity Director					9
10	Activity Assistants	6,095	6,499	52,203	8.03	10
11	Social Service Workers	1,982	2,112	32,065	15.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,728	30,216	250,389	8.29	15
16	Dishwashers					16
17	Maintenance Workers	6,189	19,424	64,074	3.30	17
18	Housekeepers	16,451	17,908	134,494	7.51	18
19	Laundry	7,284	8,221	61,115	7.43	19
20	Administrator	1,960	2,080	91,924	44.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,648	6,276	80,893	12.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beautician	1,000	1,000	0	0.00	33
34	TOTAL (lines 1 - 33)	197,247	224,770	$ 2,363,380 *	$ 10.51	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		2,888		36
37	Medical Records Consultant		6,207		37
38	Nurse Consultant				38
39	Pharmacist Consultant		100		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,996		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 13,191		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Frank Shepke	Administrator		$ 91,924
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,924

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Mgt Fee	$ 329,617
Abbott & Co	Audit	8,400
		0
		0
		0
Legal--Adjusted to Zero		5,019
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 343,036

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,707
Unemployment Compensation Insurance	1,984
FICA Taxes	180,799
Employee Health Insurance	174,326
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	120,723
Employee Benefits - central office	
TOTAL (agree to Schedule V, line 22, col.8)	$ 547,539

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,900
Advertising: Employee Recruitment	559
Health Care Worker Background Check	
(Indicate # of checks performed)	600
Central Office Allocation	
Promotional Advertising	13,705
Public Relations	7,716
Dues and Subscriptions	8,243
License and Fees	578
Less: Public Relations Expense	(7,716)
Non-allowable advertising	(375)
Yellow page advertising	(13,705)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,505

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,004
	114
Seminar Expense	2,609
	(2,728)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 1/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Clara's Manor # 0016949 **Report Period Beginning:** 1/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **76,650**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **13**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Sulaski & Webb** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Report not Available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount							
1009			PETTY CASH	2,404,232							1,009	1,009 PETTY CA	2,404,232			
1010			CASH IN BANK								1,100	1,100 ACCTS RE	553,124			
1040			CASH IN BANK-PAYROLL								1,101	1,101 ALLOW. FOR UNCOLLECTIBLES				
1100			ACCOUNTS RECEIVABLE	553,124							1,110	1,110 ACCTS RECEIV-M/C				
1110			MEDICARE RECEIVABLES								1,125	1,125 ACCTS RECEIV-IPA				
1125			IPA INCOME RECEIVABLE								1,135	1,135 ACCTS RECEIV-IC				
1130			MEDICARE COST REPORT								1,140	1,140 UNAPPLIED CASH RECEIPTS				
1135			ACCOUNTS RECEIVABLE-IC								1,145	1,145 A/R SUSPENSE-REFUNDS				
1140			UNAPPLIED CASH RECEIPTS								1,200	1,200 PREPAID I	105,281			
1145			A/R SUSPENSE-REFUNDS								1,220	1,220 OTHER PREPAID EXPENSES				
1190			ACCRUED INTEREST REC								1,300	1,300 DIETARY INVENTORY				
1200			PREPAID INSURANCE	105,281							1,310	1,310 SUPPLIES INVENTORY				
1220			OTHER PREPAID EXPENSES								1,320	1,320 LINEN INVENTORY				
1300			FOOD INVENTORY								1,409	1,409 LAND	65,863			
1310			SUPPLIES INVENTORY								1,450	1,450 FURNITUF	1,179,387			
1409			LAND	65,863							1,460		-921,976			
1450			FURNITURE & EQUIPMENT	1,179,387							1,475	1,475 CODE ALE	2,596,806			
1460			ACCUM DEPR-FURN & EQUIP	-921,976							1,490	1,490 ACCUM DI	-1,809,709			
1475			BUILDING & IMPROVEMENTS	2,596,806							1,530	1,530 RESIDENT	12,673			
1490			ACCUM DEPR-BUILDING	-1,809,709							1,550	1,550 LOAN FEE	0			
1530			RESIDENT FUNDS	12,673							1,551	1,551 LOAN FEES ADDED				
1550			LOAN FEES	0							1,850	1,850 INTERCOM	-56,823			
1560			REAL ESTATE TAX ESCROW								2,010	2,010 ACCOUNT	-267,996			
1575			REIMBURSABLE PURCHASES								2,100	2,095 BONUSES PAYABLE				
1850			INTRACOMPANY	-56,823							2,100	2,100 ACCRUED	-42,911			
2010			ACCOUNTS PAYABLE	-267,996							2,100	2,100 PR CLEARING-BENEFITS				
2095			BONUSES PAYABLE								2,100	2,100 PR CLEARING-LABOR				
2100			ACCRUED PAYROLL	-42,911							2,110	2,110 ACCRUED	-99,442			
2110			ACCRUED VACATION PAY	-99,442							2,120	2,120 U.C. TAXES PAYABLE				
2120			UC TAXES PAYABLE								2,125	2,125 FICA TAXI	-25,807			
2125			FICA TAX PAYABLE	-25,807	-25,807						2,130	2,130 FEDERAL W/H TAX PAYABLE				
2130			FIT PAYABLE								2,140	2,140 STATE W/H TAX PAYABLE				
2140			STATE W/H PAYABLE		0						2,152	2,152 WORKERS COMP ACCRUAL				
2145			EARNED INCOME CREDIT								2,225	2,225 EMPLOYEEE INSURANCE REFUND				
2150			UC FED CREDIT REDUCTION								2,230	2,230 PAYROLL SAVINGS				
2230			PAYROLL SAVINGS								2,235	2,240 UNITED FUND				
2235			IRA W/HOLDINGS								2,240	2,246 GROUP INSURANCE - CAFETERIA				
2240			UNITED WAY								2,246	2,250 401K W/H				
2245			GROUP INSURANCE PAYABLE								2,250					
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2,260	2,260 WAGE GARNISHMENT				
2260			WAGE GARNISHMENTS								2,300	2,300 ACCRUED	0			
2280			MISC PAYROLL DEDUCTIONS								2,320	2,320 IPA PAYM	0			
2300			ACCRUED INTEREST PAYABLE	0							2,350	2,350 REAL EST.	0			
2310			SALES TAX PAYABLE								2,385		0			
2320			IPA PAYMENTS PAYABLE	0							2,400	2,400 CURRENT PORTION OF LT DEBT				
2350			REAL ESTATE TAX PAYABLE	0							2,512	2,512 DUE TO RI	-12,673			
2385			ACTIVITY FUND	0							2,600	2,600 LASALLE	0			
2390			SECURITY DEPOSITS	0							2,600					
2391			VOLUNTEER FUND								2,625	2,625 LASALLE	0			
2393			HEART FUND/BAZAAR								2,625					
2395			DEFERRED INC EMP & MEM								2,695	2,695 CURRENT PORTION OF LT DEBT				
2400			CURRENT PORTION LT DEBT								2,720	2,720 RETAINED	-2,889,493			
2460			INCOME TAXES PAYABLE									net income	-790,536			
2512			DUE TO RESIDENTS	-12,673												
2600			MORTGAGE PAYABLE	0												
2650			EQUIPMENT LOAN PAYABLE									balance	0			
2695			CURRENT PORTION LT DEBT													
2696			DEFERRED INCOME TAXES													
2710			COMMON STOCK													
2720			RETAINED EARNINGS	-2,889,493												
2970			PROFIT/LOSS FOR PERIOD	-790,536												
3007.1			PATIENT DAYS-PRIVATE	18,694										3,007	3,007 PATIENT I	18,694
3007.2			PATIENT DAYS-IPA	20,056										3,007	3,007 PATIENT I	20,056
3007.3			PATIENT DAYS-MEDICARE	4,527										3,007	3,007 PATIENT I	4,527
3007.4			PATIENT DAYS-CONVERSION											3,007		0
3007.5			PATIENT DAYS-LICENSED											3,007		
3007.6			PATIENT DAYS-TOTAL											3,007		
3010		1	BASIC CHARGE-PRIVATE & VA	-5,359,960		0	0	0	0					3,007		
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0					3,010		(5,359,960)
3020		1	BASIC CHARGE-IPA	0		0	0	0	0					3,020		
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0					3,030		
3035		4	DAY CARE/HOME CARE			0	0	0	0					3,040		
3040		1	LIGHT NURSING CARE	0		0	0	0	0					3,050		
3050		1	MEDIUM NURSING CARE			0	0	0	0					3,060		
3060		1	HEAVY NURSING CARE			0	0	0	0					3,061		
3061		1	SKILLED NURSING CARE											3,080		(65,281)
3080		1	NURSING SUPPLIES-PRIVATE	-65,281		0	0	0	0					3,081		
3081		1	NURSING SUPPLIES-IPA			0	0	0	0					3,082		
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0					3,083		
3083		1	NURSING SUPPLIES MED PT B											3,100		(263,572)
3100		17	DRUGS	-263,572		0	0	0	0					3,101		
3101		17	DRUGS-OTHER											3,110		(564,491)
3110		6	PT-PRIVATE	-564,491		0	0	0	0					3,111		
3111		6	PT-IPA			0	0	0	0					3,112		
3112		6	PT-MEDICARE PART A			0	0	0	0					3,113		
3113		6	PT-MEDICARE PART B			0	0	0	0					3,140		
3130		1	PUBLIC AID ASSESSMENT INC											3,150		
3140		19	LABORATORY INCOME			0	0	0	0					3,151		
3150		6	SPEECH/OT-PRIVATE			0	0	0	0					3,152		
3151		6	SPEECH/OT-IPA			0	0	0	0					3,153		
3152		6	SPEECH/OT-MED PART A			0	0	0	0					3,160		
3153		6	SPEECH/OT MED PART B											3,410		784,686
3410		2	IPA DISCOUNTS	788,541		0	0	0	0					3,411		
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0					3,420		
3420		2	MEDICARE DISCOUNTS			0	0	0	0					3,500		
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0					3,520		
3520		16	RENT INCOME	0		6	0	6	0					3,530		(19,112)
3530		13	BEAUTY SHOP	-19,112		0	0	0	0					3,560		(517)
3560		12	ACTIVITY FUND INCOME	-517		0	0	0	0					3,570		(1,584)
3570		12	VENDING INCOME/EXPENSE	-1,584		0	0	0	0					3,590		(3,584)
3580		12	MANAGEMENT FEES			0	0	0	0					3,595		
3590		1	EQUIPMENT RENTAL	-3,584		0	0	0	0					3,600		(206)
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0					4,110		80,893
3600		21	MISC INCOME	-206		0	0	0	0					4,111		91,924
4110			GENERAL & ADMINIST WAGES	80,893	80,893	21	1	17	0					4,115		
4111			ADMINISTRATOR WAGES	91,924	91,924	17	1	0	0					4,120		121,954
4115			VACATION & SICK - G&A	0		21	1	0	0					4,125		
4120	4475		EMPLOYEE BENEFITS	120,723	547,539	22	3	0	0					4,130		
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0					4,135		
4130			EMPLOYEE SCHOLORSHIP WA(	0		21	1	0	0					4,250		6,994
4135			EMPLOYEE SCHOLORSHIP COS	0		23	3	0	0					4,255		4,154
4220			DIRECTORS FEES	0	0	18	3	0	0					4,260		17,675
4250	4255		OFFICE SUPPLIES	11,148	11,148	21	2	0	0					4,275		1,999
4260			TELEPHONE	17,675	17,675	21	3	0	0					4,276		2
4275			TRAINING & EMPLOYEE DEVL	1,999	1,999	23	3	16	0 **					4,280		2,004
4280			GENERAL TRAVEL	2,004	4,727	24	3	16	0					4,281		114
4281			MEAL EXPENSE FOR TRAVEL	114		24	3	19	0					4,285		2,609
4285			EDUCATION & SEMINAR	2,609		24	3	19	-2,728 ***					4,289		
4290			HELP WANTED ADVERTISING	559	109,951	20	3	0	0	-76,650				4,290		559
4291			PROMOTIONAL ADVERTISING	13,705		20	3	25	-13,705					4,291		13,705
4292			PUBLIC RELATIONS	7,716		20	3	25	-7,716					4,292		7,716
4300			LICENSES & FEES	79,128		20	3	17	0					4,300		79,128
4310			DUES & SUBSCRIPTIONS	8,243		20	3	17	-375					4,310		8,243
4320			CONTRIBUTIONS	0		27	3	20	0					4,320		
4350			PROFESSIONAL FEES	13,419	343,036	19	3	22	-5,019					4,350		13,419
4355			MEDICAL DIRECTOR	2,888	2,888	9	3	0	0					4,355		2,888
4360			UTILIZATION REVIEW	0		10	3	0	0					4,362		6,207
4361			OTHER PHYSICIAN FEES	0		39	3	0	0					4,363		100
4362			MEDICAL RECORDS CONSULT	6,207		10	3	0	0					4,364		3,996
4363			PHARMACIST FEES	100		10	3	0	0					4,370		642
4364			SOC SERV/ACT CONSULT	3,996	3,996	12	3	0	0					4,383		600
4370			TV RENTAL	642		35	3	5	-366					4,390		
4380			INCOME TAXES		60,000	27	3	26	0					4,400		173,241
4383			BACKGROUND CHECKS	600		20	3	26	0					4,401		9,542
4400			PAYROLL TAXES	173,241		22	3	0	0					4,410		174,326
4401			PAYROLL TAXES ADMINIST	9,542		22	3	0	0					4,420		85,907
4410			GROUP INSURANCE	174,326		22	3	0	0					4,430		66,238
4420			LIABILITY INSURANCE	85,907	85,907	26	3	0	0					4,435		2,968
4425			INSURANCE-OWNERS			22	3	21	0					4,436		499
4430			WORKMENS COMP INSURANCI	69,707		22	3	0	0					4,450		329,617
4450			CENTRAL OFFICE FEES	329,617		19	3	34	0					4,460		60,000
4460			BAD DEBTS	60,000		27	3	24	-60,000					4,461		3,855
4470			LOST ITEMS-RESIDENTS	0		27	3	0						4,470		
4490			MISCELLANEOUS	0		27	3	0	0					4,475		(1,231)
4510			REAL ESTATE TAXES	0	0	33	3	0	0					4,486		6,816
4600			LEASED EQUIPMENT	6,792	7,434	35	3	16	0					4,490		(1,263)
5110			MAINTENANCE SALARIES	63,075	64,074	6	1	0	0					4,496		
5120			MAINTENANCE SICK & VAC	999		6	1	0	0					4,510		
5130			ELECTRIC	59,875	116,682	5	3	0	0					4,600		6,792
5131			NATURAL GAS	32,510		5	3	0	0					5,110		63,075
5132			HEATING & DEISEL OIL			5	3	0	0					5,120		999
5133			WATER & SEWER	24,297		5	3	0	0					5,130		59,875
5134			TRASH COLLECTION	5,981	34,854	6	3	0	0					5,131		32,510
5140			PROPERTY PLANT REPLACEM!	6,440	43,718	6	2	0	0					5,133		24,297
5160			GENERAL REPAIR & MAINT	37,278		6	2	0	0					5,134		5,981
5165			MAINTENANCE CONTRACTS	28,873		6	3	0	0					5,140		6,440
5210			DIETARY WAGES	240,483	250,389	1	1	0	0					5,160		37,278
5220			DIETARY SICK & VAC	9,906		1	1	0	0					5,165		22,057
5240			SALES TAX			2	3	13	0					5,210		240,483
5248			FOOD PURCHASES	220,463	220,450	2	2	0	0					5,220		9,906
5250			SUPPLIES-DISHWASHING	6,903	23,503	1	2	0	0					5,248		221,726
5260			DIETARY REPLACEMENT	10,289		1	2	0	0					5,250		6,903
5270			KITCHEN SUPPLIES-PAPER	6,311		1	2	0	0					5,260		10,289
5295			MEAL CREDIT	-13		2	2	0	0					5,270		6,311
5310			LAUNDRY WAGES	59,926	61,115	4	1	0	0					5,295		(13)
5340			LAUNDRY SICK & VAC	1,189		4	1	0	0					5,310		59,926
5370			LAUNDRY REPLACEMENT	4,873	12,280	4	2	0	0					5,340		1,189
5380			LAUNDRY REIMBURSEMENT			4	3	0	0					5,370		4,873
5390			LAUNDRY SUPPLIES	7,407		4	2	0	0					5,380		
5410			HOUSEKEEPING WAGES	131,893	134,494	3	1	0	0					5,390		7,407
5440			HOUSEKEEPING SICK & VAC	2,601		3	1	0	0					5,410		131,893
5480			HOUSEKEEPING SUPPLIES	4,011	18,777	3	2	0	0					5,440		2,601
5490			HOUSEKEEPING SUPPLIES-PPR	14,766		3	2	0	0					5,480		4,011
6010			RN WAGES-MEDICARE		1,596,223	10	1	0	0					5,490		14,766
6020			RN WAGES-NON MEDICARE	51,541		10	1	0	0					6,020		51,541
6030			DON WAGES	69,318		10	1	0	0					6,030		69,318
6035			ADON	62,798		10	1	0	0					6,035		62,798
6040			RN SICK & VACATION	1,277		10	1	0	0					6,040		1,277
6110			LPN WAGES-MEDICARE	0		10	1	0	0					6,120		489,663
6120			LPN WAGES-NON MEDICARE	489,663		10	1	0	0					6,140		24,273
6130			LPN WAGES OTHER			10	1	0	0					6,220		783,744
6140			LPN SICK & VACATION	24,273		10	1	0	0					6,240		68,467
6210			AIDE WAGES-MEDICARE			10	1	0	0					6,245		
6220			AIDE WAGES-NON MEDICARE	783,744		10	1	0	0					6,246		
6230			WARD CLERKS			10	1	0	0					6,247		
6240			AIDE VACATION & SICK	68,467		10	1	0	0					6,250		
6245			CONTRACT NURSES-RN	0		10	3	0	0					6,255		500
6246			CONTRACT NURSES-LPN	0		10	3	0	0					6,260		
6247			CONTRACT NURSES-AIDES	0		10	3	0	0					6,270		43,309
6250			NURSE AIDE TRAINING WAGES	0	0	13	1	0	0					6,275		1,833
6255			NURSE AID TRAINING EXP	500	500	13	2	0	0					6,290		42,082
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0					6,295		86,663
6270			REHAB WAGES	43,309		10	1	0	0					6,390		10,421
6275			REHAB SICK & VAC	1,833		10	1	0	0					6,490		1,466
6280			NURSING DEPT EDUCATION			23	3	0	0					7,280		140,400
6290			NURSING SUPPLIES	42,082	139,166	10	2	0	0					7,281		
6295			NURSING SUPPLIES	86,663		10	2	0	0					7,380		20,908
6390			REPLACEMENT-NURSING	10,421		10	2	0	0					7,391		20,996
6490			NURSING OTHER	1,466	7,773	10	3	0	0					7,393		
7280			DRUG PURCHASES	140,400	140,985	39	2	0	0 ***					7,510		50,752
7281			DRUG PURCHASES-OTHER	0		39	2							7,540		1,451
7380			LABORATORY SERVICES	41,904	269,517	39	3	0	0					7,590		5,646
7410			HOME HEALTH SALARY			39	1	0	0					7,620		155,924
7440			HOME HEALTH SICK & VAC			39	1	0	0					7,660		585
7450			HOME HEALTH EXPENSES			39	3	0	0					7,710		30,713
7510			ACTIVITES WAGES	50,752	52,203	11	1	0	0					7,720		1,352
7540			ACTIVITIES SICK & VAC	1,451		11	1	0	0					7,730		243
7590			ACTIVITIES SUPPLIES	5,646	5,646	11	2	0	0					7,740		58,631
7595			ACTIVITIES FEES	0	0	11	3	0	0					7,750		
7610			PT WAGES			39	1	0	0					7,770		13,058
7611			PT SICK & VACATION			39	1	0	0					7,820		16,852
7620			PT FEES	155,924		39	3	0	0 ***					7,890		231
7660			PT SUPPLIES	585		39	2	0	0					7,960		
7710			SOCIAL SERVICE WAGES	30,713	32,065	12	1	0	0					8,120		3,704
7720			SOCIAL SERVICE SICK & VAC	1,352		12	1	0	0					8,125		
7730			SOCIAL SERVICE EXPENSES	243	243	12	2	0	0					8,130		141,396
7740			OT FEE	58,631		39	3	0	0 ***					8,150		
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0					9,510		(56,727)
7770			SPEECH THERAPY FEE	13,058		39	3	0	0 ***					9,520		
7800			BEAUTICIAN WAGES		0	40	1	0	0					9,530		
7810			BEAUTICIAN SICK & VAC			40	1	0	0							
7820			BEAUTICIAN FEES	16,852	16,852	40	3	0	0							
7890			BEAUTY SHOP SUPPLIES	231	231	40	2	0	0							(790,536)
7910			VOLUNTEER COORDINATOR			21	1	0	0							
7940			VOL COORD SICK & VAC			21	1	0	0							
7960			VOL COORD SUPPLIES	0		21	2	0	0							
8100			RENT		0	34	3	0	0							
8120			INTEREST EXPENSE	3,704	3,704	32	3	14	-3,704							
8130			DEPRECIATION	141,396	141,396	30	3	9	0							
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	60,773						
9510			INTEREST INCOME	-56,727		32	0	10	0							
9520			MISC NON-OPERATING INCOM	0		0	0	0	0							
9700			INCOME TAXES	0		0	0	0	0							
				4,699,230	4,755,957											
					56,727											
GRAND TOTALS				-790,536					-93,613							
				(NET INCOME)												
				0												

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0
173,113

	G/L	RECAP CENSUS
PP	18,694	18,676
IPA	20,056	20,056
medicare	4,527	4,527
		43,259

IPA BEDHOLDS	0
PP BEDHOLDS	18
PP CONVERS	0
	0